

Chapter 3

Understanding Sociocultural Aspects of Alcohol and Other Drug Use

Introduction

This chapter describes major sociocultural concepts, definitions, and processes that are important for understanding why people use and develop problems with alcohol and other drugs, and that affect whether and how they might best address problems once they have developed. The chapter also introduces important sociocultural dimensions on which people differ from each other.

These differences add richness and diversity to the world; they also lead people to misunderstand and label each other. Further, the differences among people help to determine perceived social worth, since, in all societies, people with some characteristics are valued more than people with other characteristics.

In combination, sociocultural characteristics help to define who people are, the structure of their lives, and the life options or difficulties they are likely to face. They affect whether and how alcohol and other drugs are used and whether problems develop. Two important questions will be posed throughout the discussion of sociocultural dimensions:

- (1) How can we be sensitive—in research, social policies, treatment, and prevention programming—to *differences* among people that are shaped heavily by sociocultural processes?
- (2) How can we apply sociocultural principles to improve prevention and treatment for groups whose opportunities and rights may be limited by sociocultural processes?

These questions are important for several reasons. As noted in Chapter 1, for prevention and treatment, practices for alcohol and other drug use developed over the years with a focus on a major similarity among those who developed problems with alcohol and other drugs. Although scholars were studying the impact of cultural patterns on drinking and other drug use, little attention was paid to other aspects of the person in treatment, such as the social groups they were part of, and their life circumstances. It was as if *only* the struggle with the alcohol and other drug-related problems was important in treatment and prevention planning.

Most of those developing the early models of intervention were men with similar backgrounds, and their perspectives and values dominated policies and programming for many years. Whether or not this was justified in terms of numbers is not clear, since careful epidemiological studies were not done until later. The most common persons in treatment for alcohol problems were Caucasian, middle-aged, working-class men in late stages of excessive use, often with serious health problems. For other (illicit) drugs, men were still the primary providers and recipients of services, although the recipients were younger, and more often from urban centers. Their ethnic and racial backgrounds were more diverse than those who primarily used alcohol.

Resources became more available for prevention and treatment programming when the public became concerned about drugs moving into suburban, middle-, or upper-class (primarily Caucasian) neighborhoods. Before this, the intervention most frequently used was incarceration, and unfortunately, for young, inner-city men-of-color, this is still the most common intervention.

Attention to women and girls came even later.

While we have limited evidence about the effectiveness of alternative strategies for members of different sociocultural groups, most dominant treatment models include assumptions derived from the needs, coping styles, and life circumstances of the men who were the original targets and planners of treatment and prevention models. These approaches may not serve the needs and styles of other groups, on many of the dimensions described in this chapter. They are especially unlikely to take into account the effects of discrimination or limited opportunities. In fact, they often do not even attend to important differences *among* Caucasian men, and may perpetuate some stereotypical aspects of masculinity that are not healthy for men or for their friends and family.

What Are Sociocultural Concepts?

The concepts usually defined as **sociocultural** focus on societal elements, patterns, and groupings larger than the individual. These groupings include families, peer groups (such as friends or co-workers), environments in which people live (neighborhoods, communities), areas defined by geography and climate (regions, continents), those with similar customs and histories, or a shared governance (including states, countries, religions, ethnic groups).

Sociocultural concepts encompass ways that individuals, groups, and societies are defined and define themselves, on many dimensions. Some of the dimensions might include social values, customs, behaviors that are valued or prohibited, social rituals, belief systems, responsibilities, and rights. They might focus on how social worth and value are determined, how the work needed to sustain the society is divided and shared, how resources are distributed, and how all of these are related to each other.

The dimensions would also apply to the institutions that every society creates in order to:

- Take care of the young and help them become productive community members (e.g., families, schools, religious institutions).
- Develop and distribute resources needed for survival (e.g., farms, banks, factories, stores, various forms of housing, human services organizations).
- Set priorities, develop rules, and regulate conflicts among institutions, groups, and individuals (e.g., government, courts, the United Nations).
- Help to shape and express the meanings of life (e.g., religion, the arts, literature).
- Set standards and advocate for the needs of particular groups (e.g., professional organizations, unions, social movement groups).

This chapter will pay special attention to how relationships, group and organizational “memberships,” social policies and practices, cultural values and structures, and institutional rules and procedures help to define the identities of individuals and groups as a part of a larger whole. These definitions can lead people to feel that they “belong” and have a sense of worth, or to feel different or even to be excluded from many rights and privileges that others have. We will stress how society regulates individual and group behaviors to maintain social order, and to balance the individual’s desires and rights with those of others and the society as a whole.

The concepts considered in this chapter come from many areas of study, in particular, sociology; anthropology; and social, organizational, and community psychology. Ideas are also drawn from

political science, economics, linguistics, and history.

Why Are Sociocultural Concepts Useful and Necessary?

Sociocultural theories and research provide a set of ways for understanding the purposes that alcohol and other drug use serve in people's lives and societies, and how social forces can keep use quite limited or can allow (or even promote) the development of alcohol and other drug-related problems. Since sociocultural concepts focus on key elements of the "larger picture," they can help illuminate the history of the alcohol and other drug fields and their current issues. In Chapter 1, we described the origins and consequences of the deep ambivalence about alcohol and other drug use in this country. These concepts can also be used to examine our country's often conflicting social policies and programs over the years and the consequences of these policies.

Although sociocultural thinking focuses on larger social systems, many aspects of the treatment of individuals have also been influenced by sociocultural research. For instance, understanding the importance of rituals within families and the larger culture in creating structure and meaning for individuals and groups has led counselors to create rituals within programs that mark important transitions (e.g., graduation ceremonies) and within individual treatment plans to symbolize key goals, such as a funeral in which individuals invite family and friends to watch them officially bury drug supplies and equipment (paraphernalia) to mark the beginning of work toward abstinence.

Similarly, recognizing the influence of social groupings in shaping the behaviors of members has led counselors to involve family members and friends in treatment programs, in order to change some of the sociocultural factors that contribute to the individual's problems and to support the individual through treatment.

Sociocultural approaches have contributed even more to an understanding of prevention. While strategies directed toward the individual are important (see Chapters 4 and 5), sociocultural approaches affect larger groups of people and many conditions that contribute to the development and continuation of alcohol and other drug problems in many different types of people.

Some Key Dimensions of Identity and Group Membership

On the left-hand side of Figure 3.a, we list some key elements of identity and group membership that influence people's behavior. Elements of identity are key factors of group membership. Most of these we acquire at birth, based on the social position of our parents or because of some physical characteristic (e.g., our appearance) although some we may earn or choose. Some elements of identity may change over the course of our lives (for example, age, education, or becoming disabled through an accident or injury). We have grouped categories on the left-hand side because all are important contributors in this society to social status—a term that means how much the larger society values who one is, the opportunities and the amount and types of power and influence that one has, and the types of barriers one encounters. In every society some categories of people have more status than others, although what determines that status may vary in different cultures. We will discuss later in this chapter how those with lower status often experience prejudice and discrimination; these experiences can be important to consider within alcohol and other drug prevention and treatment programs. Those with higher status also are shaped by that status in ways that have implications for the prevention and treatment of problems

with alcohol and other drugs. On the right-hand side of Figure 3.a, we list a number of sociocultural concepts and processes—terms that describe some of the ways that the larger society and elements within it help to shape and control how people perceive themselves and each other and how they behave. These include how our lives are structured, groups to which we belong, and the multiple ways that our institutions and practices affect us.

All of the elements included in Figure 3.a help to shape whether one uses alcohol and other drugs, which drugs one uses, in what way and where, and with what degree and types of problems. We will discuss all of the elements throughout this chapter, revisiting them in later chapters, particularly Chapters 7 and 9.

Age, Life Course Issues, and Developmental Tasks

We begin our discussion of sociocultural dimensions from Figure 3.a with age and the life cycle since we all have experience with the changing nature of what we and others expect of people at different ages.

Expectations about behavior, social rights and responsibilities, major life tasks, and the value accorded to one by society all vary through the life cycle. Physically, children and adults go through well-known stages of growth and development, with physical abilities peaking in the late teens or early twenties, and a gradual decline that accelerates in the fifth decade of life. Language and cognition (thinking), creativity, personality, social relations, and the roles one plays and how one plays them all undergo changes throughout the life course.

Different patterns, purposes, and risks in the use of alcohol and other drugs can emerge as one grows up. Life **transitions** are times of special vulnerability since the individual has to adjust to many changes. The timing of these changes can be very important. When the changes are expected and many people are experiencing them together, there is often much social support to be gained by sharing experiences with others “in the same boat.” When the changes happen at unexpected times, they are more difficult and disruptive. Thus, the timing and sequence of events like marriage or divorce, pregnancy, becoming a parent, adapting to developmental stages and issues of children, losing a job, or becoming ill or disabled can either feel like the next logical step in life or be a major disruption.

Times of major transition are often high-risk periods for illness, problems with alcohol and other drugs, depression, and so forth. Whether problems develop will depend on the individual’s coping skills, but also on many sociocultural factors, such as how much social support (having others one can depend on for help of various kinds) the person has, whether they have meaningful activities to occupy their time, and whether social rituals are available to help them through the transition.

| <i>Categories of Social Status</i> | <i>Sociocultural Concepts and Processes</i> |
|------------------------------------|--|
| Age | Life course issues |
| Gender | •Developmental tasks and expectations at different life stages |
| Sexual orientation | |
| Religion | |
| Ethnicity | •Key transitions |
| Race | Norms |
| Socioeconomic class | Reference groups |
| •Education | •Peer groups |
| •Occupation | •The family |
| •Income | Social roles |
| •Residence | Cultural patterns and values |
| Disabilities/health status | •Lifestyles |
| | •Relationships and language |
| | •Rituals |
| | •Spirituality |
| | Regional differences |
| | Assimilation and acculturation |
| | Social regulation |
| | Deviance |
| | Prejudice |
| | Institutionalized discrimination |

Figure 3.a Key Sociocultural Concepts: Multiple Elements of Identities and Influences on Behavior

Adolescence

Adolescence is a major time of transition from childhood to adulthood. Bodies are changing rapidly, including sexually; relationships and thinking abilities grow and change markedly. The child is beginning to want to be more independent from parents and families. The adolescent worries about being “normal”—not too different from his or her peers—but also wants to be distinctive and a person of his or her own, especially within the family.

The beginning of what the psychologist Piaget called “formal operational thinking” brings new abilities in thinking, which often creates new idealism and an ability to be critical of things they had formerly accepted. Thus, adolescents may be suddenly argumentative and highly critical, not only of parents and teachers, but also of themselves. They may seem very preoccupied and self-centered, since new thinking abilities allow them to imagine what others are thinking about them (to play to an “imaginary audience”). They imagine that their every move is obvious to everyone around them, and thus are very self-conscious.

At the same time, because of their intense focus on themselves and their lack of experience which would allow them to understand their situations more broadly, they develop what Elkins calls a “personal fable,” a view that they are unique and that nothing similar ever happened to anyone else. The personal fable can lead the youth to feel invulnerable—that what might be a “risk” for someone else would never happen to him or her. Thus, an adolescent will take chances, even though he or she has considerable information about the possible consequences of risky behavior. Combine these feelings of invulnerability with beginning to drive a car and experimenting with alcohol and other drugs and sexuality in an age of AIDS, and you have many risks indeed! Emotional and intellectual crises centering on religion and spirituality can occur, because of new abilities to think abstractly and critically.

Adolescence is also a time of major **socialization**, learning how to be a responsible member of society. Socialization begins at birth, is a major task of parenting, and continues in churches, schools, groups of friends, and in preparation for adult tasks and relationships. Socialization also includes learning about how to be social with others, what are acceptable ways of having fun, and how to cope with problems and difficulties. These often include learning about, and using, tobacco and alcohol, as well as experimenting with other drugs in many neighborhoods and social groups. Many youths, after experimenting a bit, develop ways to limit their use to particular times, places, and activities, and use a small enough amount that problems don’t arise. For others, use occurs in patterns that suggest problems lie ahead.

Assessing the Adolescent

The assessment picture for adolescents is often complicated by a number of factors. [See the vignettes of Delia and Charles in Chapter 9.] Adolescents’ psychological profiles are often not stable and contain elements indicative of childhood patterns mixed with those suggesting more adult functioning. Other types of behaviors are often combined with alcohol and other drug use. Rebellious forms of dress or behavior, dealing drugs to augment family income or challenge the police, and other types of unhappiness (including suicide attempts) can occur with—or without—alcohol and other drug use. Distinguishing among these patterns can be difficult; nothing can be assumed.

Adolescent use patterns can resemble severe alcohol and other drug problems in an adult, and may have short-term, life-threatening consequences (like overdose or accident), but these patterns may have quite different meanings in a youth than they do in an adult. A change in environment, an increase in age and skills, or a shift to planning for the future may help a youth to change their alcohol and other drug use patterns dramatically, in a way that is probably much more difficult in an adult. Family interventions can have a quick impact on the life of an adolescent.

Before we introduce sociocultural concepts related to peer groups and families, we need to make one other point that is related to socialization. Socialization and negotiating the tasks that are important for each life stage can be seriously disrupted by particular types of alcohol and other drug use.

In treatment, the term **rehabilitation** indicates that the person is trying to recover their previous selves, skills, and performance. It implies that a person had attained adult-level skills, relationships, and ways of thinking and feeling, although some of them may need to be revised or changed to support healthier living. In treatment with adolescents, there may be deterioration that must be addressed, but there may also be socialization that is not yet finished or that has been interrupted and disrupted by the use of alcohol and other drugs. Thus “habilitation” (helping the person to develop adult coping and skills) also must be a major goal. A treatment program must work closely with the families and schools since adolescents are still strongly linked with their families and other institutions whose role is to socialize new members of society. Treatment must take into account the ways that adolescents are still changing and developing and assist them and their families with those issues.

In adult treatment programs, one must also be aware of whether a person began use in adolescence and assess how disruptive that use was to successful completion of the “tasks” of adolescence. Such individuals may be older in chronological age, but, in many respects, still act like an adolescent.

Norms

Norms are shared standards of acceptable and unacceptable behavior; members who wish to have access to a particular group then try to meet its expectations. Larger societies and communities also develop norms about how people who are members of subgroups, families, neighborhoods, states, or countries should behave. When we described earlier the ways that groups “require” their members to behave in particular ways, we were discussing norms.

Norms can be very formal, as in written “rules” for membership, or as “laws” within an organized society, or they can be very informal and subtle. Norms can include understandings about how members should dress, talk, and act, what careers and uses of time are most valuable, and how relationships should occur. Norms are modified through the positive and negative reactions of group members to the behavior of each other. People learn what behaviors are expected by watching each other, through rewards from others when one’s behavior conforms with valued norms, and by being “punished” for behavior that falls outside what is expected. Rewards and “punishments” may be formal (such as being sent to jail) or informal (like not being invited to a party). They may also vary in severity, from slight frowns on people’s faces to exclusion from group activities.

Norms are very powerful elements in regulating behavior. They make it possible for groups to meet their own needs, while co-existing with others. Norms encourage people to act in ways that benefit the greater society, and also help to define meaning and provide structure. With regard to alcohol and other drug use, norms can help to promote or prohibit first use, heavy use, and destructive behaviors.

Changing the norms of a group (or society) will affect the behaviors of everyone in the group. For instance, smoking used to be viewed as a common and acceptable adult behavior, even sexy (especially for men), and as part of important social rituals. Nevertheless, our society has changed many of the social images and standards that promoted and supported smoking through a combination of formal information campaigns about the negative health effects of first- and second-hand smoke, changes in informal attitudes about the dirtiness and smell of a “filthy habit” and the “selfishness” of exposing others to your smoke, and through laws and regulations that

require smoke-free zones.

Peer Groups

A sociocultural concept important for understanding the behavior of people of all ages, but especially relevant to alcohol and other drug use in adolescence, is the nature of groups to which a person belongs outside their family. These groups help to shape identity and provide social support. One such group is called a **peer group**. A peer group typically includes persons similar to each other in age or interest. An individual identifies with the members of the peer group, and is influenced by other members' behaviors and perceptions. A person may have relationships with many peer groups of different kinds, or may have only one. For a teen, peer groups could include team members in a sport, those who live in a particular neighborhood, members of a church, ashram, or synagogue, a club or interest group (like photography or ecology), or fellow band members. A person may feel only loosely connected with a peer group, or feel very intensely linked to the point of defining him or herself completely in relationship to that group.

Since most alcohol and other drug use is learned from others in social settings, a peer group is often an important source of influence and information about alcohol and other drugs for its members. Peer pressure to use, or peer constraints against using are often important indicators of whether someone will use, and what, where, when, and how they will use. Someone with many peer groups, or who is only loosely linked to a group is likely to be less influenced by a particular group.

Peer groups vary widely, in their structure, size, organization, and how individual members relate to each other. As a collection of individuals become a group, they develop a shared (although not necessarily spoken) understanding of being connected to each other differently than people who are not members of the group.

Some peer groups are "loose" and unstructured, with memberships that change. Variations in behaviors in these groups are more likely to be acceptable among members, for instance, how to dress, how to spend time, and whether one can have important relationships outside the group. Others have more clearly defined and more narrow "rules" for members and thus require more "conformity." In most groups, certain members have more influence than others, and people play different roles. Group acceptance and membership may be very important for members, especially in an environment in which group membership confers status (the members are viewed as more important than those who are not) or protection (in situations in which not being a member of a gang, a union, or social club could lead to violence, loss of a job, or lack of access to needed resources). Group membership is also very important for those with fewer meaningful roles *outside* the group.

Peer groups differ as to how much pressure they exert on their members to behave in particular ways. This depends in part on how similar their members are to each other (for example, in age, gender, and interests), the leadership structure they develop, and often on what they define as the group's purpose. If they perceive their environment as hostile and dangerous, one of the group's purposes may be to help members to survive. There may be great pressures for loyalty and considerable secrecy within such groups, and little would be shared with people outside the group.

Groups also differ in their leadership and influence structures. In some groups, one or more

members may make decisions for the entire group, or be able to convince other group members to join their point of view more easily or more often than other members. In other groups, leadership and influence may be shared, either spread throughout a larger group, or variable over time or with different tasks and decisions. Groups of boys and men, especially, are likely to develop leadership structures which give people different amounts of influence, and allow those with more influence to have it all of the time.

Whether a person drinks or uses other drugs—how, how much, and where—will often depend on what groups the person belongs to and what the use patterns are in these groups. The influence a group has over an individual will depend partly on how important the group is to the member, what other options the member feels are possible, how much variability in what behaviors are allowed in the group, and how much pressure the group puts on its members to conform.

Assessing the Peer Group

Understanding these patterns is important in both treatment and prevention. One can try to develop alternative patterns by working with influential members of the group. Incentives can be offered to try to change key aspects of the group, or to assist a group member who has developed problems with alcohol and other drugs to find useful memberships in other groups as part of a recovery plan.

We also see a gender difference in peer groups: Boys tend to have larger and less intimate (emotionally close) groups of peers that do things together, while girls have more intimate friendships with fewer persons. Because adolescent girls often define their worth by their boyfriends, their behavior can often be strongly influenced by what their boyfriends expect of them.

Reference Groups

A special kind of peer group is called a **reference group**, one that we use to help define who we are or wish to be. Families are often important reference groups, influencing what we believe to be important, but many other types of groups can also be reference groups. For instance, if you are preparing to be a counselor in the substance abuse field, you may think of especially good counselors, teachers, or speakers at a conference as “standards” for yourself. The standards may include the individual’s life experiences, formal training and degrees (in social work, medicine, education or psychology fields), personal characteristics (such as dedication, friendliness, honesty), dress or demeanor (how they act), or sense of ethics.

Another term you may hear for individuals who are influential in one’s life is **role model**. Members of a reference group often serve as role models for individuals and groups, because of their status in a particular reference group. We will discuss roles in greater detail in a later section.

Influence of Reference Groups On Treatment and Prevention

Knowledge of reference groups can be useful in a number of ways. If something is known about what types of persons serve (or could serve) as reference group members for particular groups, you can design a prevention program that involves people whom group members especially value. This is the rationale behind using famous sports figures as spokespersons in media campaigns targeting young people. Of course, role models will be influential only if a person admires them. Incorporating messages from the persons that others value can also help to change

norms. For example, instead of hanging out with your friends, consider the importance of an education and being a good parent, or the importance of standing up for your rights and making your own decisions about the directions for your life.

One of the functions of Alcoholics Anonymous or other self-help groups is that they become new reference groups for persons who have experienced problems with alcohol and other drugs. Changing reference groups can help people shift from defining themselves as someone without a problem (one who does not need treatment), to someone who has problems related to alcohol and other drug use, to someone who can live without alcohol and other drugs (recovering).

Collecting information about peer and reference groups can be very important in an assessment, either for prevention or treatment. In prevention, for instance, if peer groups are strong and influential in a particular community, a prevention program may want to work through those peer groups. If peer group norms are getting members into trouble—either with alcohol and other drug use or other behaviors—a prevention worker may need to work with a group to change these norms. One way to do this is to identify influential group members and involve them in the design of activities that would be accepted and relevant for their group members. Influential group members are more likely than others to be able to persuade other group members to participate, and activities developed by those whom you want to attract are more likely to “fit” members’ needs and desires.

At the school level, a prevention assessment might “map” the various peer groups that are operating, and what sorts of people are members of which groups. Some groups may communicate and cooperate more readily with school officials and other adults, but not be trusted by or influential with other groups who may define themselves as being rebels, or as not interested in school. Some peer groups may pride themselves in not using any drugs, others may approve only of the use of legal drugs, while still others may choose illegal drugs because they feel or want to be different from those who follow the rules.

Understanding other elements of the larger system can also be invaluable. Often there is a pattern of how things change, who introduces new ideas, and how ideas spread. If these patterns can be understood, they can be used to help change ideas and behaviors that are creating health problems or other types of risks in that setting.

In assessment for treatment, knowledge about peer and reference groups can help to identify what will tempt people to engage in problematic behaviors, and what will support the changes necessary to deal with alcohol and other drug-related problems. They may have to develop different relationships and group memberships if their old ones were getting them into trouble. In extreme cases, it may require moving to another environment to find more options in group membership, or to avoid obstacles in moving from group to group in the current environment.

Treatment programs frequently develop activities that help people form peer and reference groups with others going through treatment. Transferring these relationships to self-help groups or other relationships outside the treatment program can help those working on alcohol and other drug use problems to develop new peer and support groups.

Aging

While there is variability in the physical development of children, and the same child may also develop differently on different dimensions, there is even greater variability in the aging processes. [See the vignettes of Mary and Earl in Chapter 9.] Chronological age may tell you

very little about physical age and vitality or the types of role and survival issues an individual may face. The later stages of life can be rich opportunities for enjoyable leisure and volunteer activities, or times of extreme poverty and stress.

The Family

Sociocultural approaches to the **family** view it as a system with a number of components that interact with each other and with the larger environment, and describe the family's purposes within the larger society. Families provide intimacy, affection, and protection for their members and produce and socialize children. Many attitudes about alcohol and other drug use and their patterns of use are shaped within the family. A healthy, flexible family may encounter problems and periods of stress, but find ways to address them; it can adapt to meet changing circumstances. Families that get "stuck" or are not a safe place for one or more of its members are especially vulnerable to having members develop problems with alcohol and other drugs. The children of families with many problems are particularly vulnerable. You should also understand, however, that many children in these families also develop very strong survival skills. These skills may look problematic outside the family, but can be mobilized in very productive ways if they are recognized as strengths, and the person is helped to learn how to apply them in constructive ways outside the family.

Some studies of family violence have shown that the presence of alcohol tends to increase the severity and frequency of violence in the family, thus interfering with the task of providing safety to its members. Anyone working with families that have both of these problems would need to address *both*, since the presence of one will interfere with addressing the other.

Other studies have looked at families in which one member (in these studies, the father) has problems with alcohol. In some situations, he is drinking a modest amount and in others, he is abstaining. The researchers found that the family members interacted more intimately and had more fun together while the family member is drinking.¹ In these families, the alcohol allows that family to have some positive interactions, although it is also contributing to many problems.

Designers of prevention and treatment programs for families may find that families where the father has problems with alcohol resist attempts at assistance. The designer of the program must take into account the connection in these families between some positive experiences and alcohol. If the families were unable to develop other ways to interact intimately with each other and have fun together, the family's need for some fun and intimacy might create dynamics that actually encouraged the father's drinking. Although family members dislike and are badly affected by many of the problems the alcohol creates, they may need the intimacy and fun enough that these needs interfere with the abstinence they also desperately want. These underlying dynamics explain why a family member might give a celebratory bottle of wine to a person recently sober, and understanding them might help the family find other ways to celebrate. If these dynamics are strong and not addressed, the father who wants to stop drinking may need to leave the family to stay sober, and children in the family may grow up to repeat their father's pattern in their own families.

Another set of family-focused studies which investigated families where young adults were having problems with alcohol and other drug use found that the families were having difficulty moving to a stage in which the young person developed independence *apart* from the family. The drugs seem to be a way of their "leaving" emotionally, while still not being independent, and in fact, giving the parents time-consuming "rescuer" roles.^{2,3} Other studies have examined how

one family member's problems can actually begin as a way to keep a family together; for instance, the only time that parents can cooperate and feel close to each other is when they must help a child in trouble.

How Knowledge of the Family Affects Treatment and Prevention

With these views of the family, a treatment plan would need to include some attention to the interconnections described or it would be likely to fail or be incomplete. These findings also could inform prevention programming focusing on the family by helping people to understand the ways that families operate and work to develop productive patterns. Family flexibility, problem-solving skills, and knowledge about how family situations can have multiple issues combined will help to determine whether problems continue to grow or transitions are resolved more positively.

Social Roles

Before discussing gender, class, and other sociocultural dimensions, we need to introduce another sociocultural concept: the **role**. This notion describes the individual and their environment. Perhaps the best way to understand the concept of role is to think of a play written for the theater. First, an author writes a script which must be approved and funded by producers. The script defines basic elements of each character, the situation, and the other characters that interrelate. The character is further developed by a particular director, the actor playing the role, and members of the cast who play other roles. Over time, as the play is repeated, the manner in which a particular role is played undergoes change. Each new actor (and director) may interpret a role differently from those who played the role before. These changes will affect the performances of other actors.

How one actor performs a role and is believable in that role is also affected by other things about that person and the situation. For instance, other actors and the audience may view a performance quite differently if an actor isn't comfortable acting in a particular way. That discomfort is likely to be obvious to others and affect how the actor's behaviors are seen and interpreted. In addition, an audience's understanding of, and feelings for, a performance are affected by other aspects of the actor such as height, weight, speech patterns, color and texture of skin and hair, types of facial features, body movements, hair style, dress, and how he or she interacts with the other actors.

Most people play many roles at the same time (for instance, child, girl, student in first grade, grandchild, friend, sister). Each person plays multiple roles over the course of their life; infant, child, son/daughter, brother/sister, student, friend, member of many groups, life partner, parent, community member, employee, employer, and member of a particular occupation. "Who" one becomes is the result of all of these roles and the interactions among them.

The roles one plays are sources of *identity* (who I am?), *meaning* (a sense of purpose and value), and *structure* (ways to spend time, rules about how, where, and when to behave in certain ways). A person can develop problems if he or she has too *few* or too *many* roles, or there is more conflict between roles than the person can manage. These situations can lead an individual to drink, use, or engage in unhealthy behaviors to dampen the pain of these problems if other ways of dealing with them are not recognized or available.

Conflicts may occur between one's own sense of how a role should be played, and how others believe it should be played; for instance, a friend who believes that "real" men can hold their liquor and should spend regular time with their friends in the local bar while you prefer coca cola

and fishing; or a teen-aged boy who believes that having sex is his *right*, once he has paid for movie tickets and food, while his date believes that one has sex after making a commitment to an ongoing, mutually caring relationship. Many negative consequences arise when people act in ways that are not consistent with what they believe about themselves in order to meet the expectations of others. Some of these consequences directly concern alcohol and other drug use, as in the bar example above. People may drink or use in ways they cannot handle because it is expected in a particular situation. People may also drink or use as a way to avoid facing conflicts, or because they act in ways that others expect, but that are not comfortable or have negative consequences for them; for instance, they feel guilty, get pregnant, or experience being violated.

Role conflicts can also occur when different persons or groups of role-senders have different expectations for the same role. A young father's friends, for instance, may expect a time commitment and behaviors from him that conflict with his wife's wishes for him to stay home and assist her with parenting. In adolescence, peer group expectations about partying may clash with parental expectations about doing one's homework and getting good grades. Other role conflicts exist *between* roles; when, for instance, the time and behavior expectations of a job (for instance, long work days, entertaining responsibilities, being present and on time) conflict with family responsibilities (for instance, being home for dinner, taking a sick child to the doctor, or helping one's parents when they need you).

If people cannot find ways to make reasonably comfortable choices among, or to partially meet, conflicting demands like these, drinking or drug use can be at least a temporary escape from the guilt, anger, and hopelessness that major conflicts can cause. Other ways to deal with conflicts can be to get the people who relate to you in different roles to understand more about other demands, and change their own so there is a better fit. One can end up playing many roles—and do it badly. One can also leave a role.

Using Role Analysis for Treatment and Prevention

Role analysis can be very useful. In treatment, for example, people may need to identify and develop ways to address role-related conflicts in their lives in order to cope with their lives without alcohol and other drugs. For intervention with people beginning to experience problems, role analysis can help to define what is influencing an individual's behavior and to identify possible options for reducing negative influences. Role analysis can also be a key tool in prevention, helping to create consistent and positive expectations about having fun, spending time together, and building meaningful relationships that do not involve destructive use of alcohol and other drugs.

Gender

The labels and behavioral expectations linked to one's biological gender are major components of one's identity and life options within most societies. The content of these gender role expectations differs from society to society, but most societies have different expectations associated with gender throughout the life cycle. These expectations shape how one is perceived by others, the nature of the relationships one is expected to have, and the opportunities available within the society.

In this society, the terms male and female are often used in ways that some describe as bipolar, meaning that male and female are defined as “opposites” with appropriate male behaviors at one

end of a continuum and appropriate female behaviors at the other. The expression “the opposite sex” illustrates this polarity. Strong **stereotypes** about what women and men are like help to perpetuate these divisions. A stereotype is a widely shared set of expectations about how someone in a particular role or with particular characteristics should behave. For example, men are “strong and silent”; women “pretty and compliant.” Often, men and women are assigned different spheres within the society as well, with women responsible for the home and children and men assigned the responsibility of acquiring resources for the family.

Unfortunately, these separations can lead each gender to have rigid ideas about appropriate behavior, and boys and girls, men and women, are restricted from some life options that would fit their skills and orientation. In the economic realities of the current world, it is increasingly unrealistic to assume that men always can or will be the primary wage-earner. Also, children need both parents to be involved fully in their lives and development.

While there certainly are biological differences between women and men, many of them do not imply the polarity suggested by the dominant stereotypes. Current studies suggest that many aspects of our assumptions about gender are “socially constructed”; in other words, developed from cultural expectations and through socialization practices, and not determined primarily by biological forces. Increasingly, researchers are making distinctions between four concepts that are often merged in ways that are problematic.

The first of these concepts is **gender**, which refers to biological differences as they are understood and interpreted socioculturally. The second is **gender identity**, defined as a person’s sense about which gender he or she is. This is a fundamental part of who we believe we are, develops very early (prior to age two), and is very resistant to change. Transsexuals are those who have a gender identity that differs from their biological characteristics; they believe they are women trapped in men’s bodies, or vice versa. At this time, no one knows why some people develop these types of gender identities. **Gender role** is the third concept, and refers to those behavioral expectations that we associate with gender in a given society. These change over the life cycle (for example, we have different expectations for little boys than we do for men at different ages) and in different times of history (the changes in clothing and in music, for instance). **Sexual object choice** or sexual orientation is the fourth concept, and refers to what or who arouses someone sexually. Most think of only two sexual orientations: heterosexual (attraction to people of the other gender) or homosexual (attraction to people of the same gender). Actually, many other orientations are also possible, including being asexual (not interested in sexual activity) or bisexual. People’s preferences often change at different periods of their lives, and there may be biological factors that influence sexual orientation, although the evidence is yet unclear.

Sexual object choice is not related directly to either gender identity or gender role. People with nonheterosexual sexual orientations are clear about which gender they are and about gender role expectations. The overwhelming tendency within the society to confuse all of these terms is very problematic in that it limits people’s options, and reinforces rigid and often destructive aspects of gender role stereotypes. [See the vignettes of John and Lisa in Chapter 9.]

Although there have been many changes in gender role expectations, socialization to prepare people for adult roles is still strongly influenced by stereotypical definitions of gender. These include expectations about drinking and use of other drugs, and the consequences that are associated with use. In general, role expectations about boys and men include more tolerance for “rule-breaking” behaviors (“boys will be boys”) while girls and women are expected to act in

more socially acceptable ways (“girls should be good”) and are more severely “punished” than boys or men if they behave in less acceptable ways. Men are rarely called promiscuous, for instance.

These expectations carry over into alcohol and other drug use. Women are more likely to use socially acceptable drugs; those prescribed by physicians, for instance. Although it is more acceptable for women to drink than it used to be, being drunk is still less acceptable for women, as is use of illegal drugs. Men have been more likely to use less socially acceptable drugs, and those drugs were often used as excuses for rule-breaking behavior; for example, drunk driving, fights, sexual activity.

When society has intervened with particular behaviors, the behaviors and consequences of concern have also been influenced by gender role assumptions and expectations: for men, they have been concerned with violence and product/work force disruption; for women, pregnancy and family disruptions. These “gendered” assumptions create more stigma (negative reactions) for women, and cause us to overemphasize some problems and neglect others for both genders.

Influence of Gender On Treatment and Prevention

We noted earlier that our treatment programs were developed primarily *for men by men*, and often perpetuated narrow definitions of masculinity. Much new information about both women and men is becoming available which continues to change our treatment assumptions and models substantially. The field has also paid little attention to either gender or cultural differences in prevention programming until recently, and we are likely to find such programs to be more effective if they incorporate knowledge of these differences.

Culture

We have alluded earlier to many elements of **culture**, usually defined as the way each society organizes and defines itself. We have discussed some of the ways that societies regulate the behavior of their members and provide structure, predictability, and meaning through social rituals, expectations about behavior, and the organization of work and play. Alcohol and other drug use can be components of rituals.

In this section, we will expand on some elements of culture and discuss several important elements related to culture that influence whether and how alcohol and other drugs are used, and how attention to these differences might strengthen prevention and treatment programs. Different cultures have had different relationships with alcohol and other drug use, some of which we indicated in Chapter 2. Different countries have different rates of use and different levels and types of problems. In some countries wine is important with meals; in others, most alcohol use is discouraged. These orientations lead to different regulatory mechanisms and different definitions about what is problematic. Exploring what words a culture uses with regard to alcohol and what problems are defined as alcohol-related can help one to understand the ways that society has understood and incorporated alcohol use.

Religion

An important element that most would define as a critical component of culture is religion. Religions are formal organizational structures within a society. Religious or spiritual beliefs and

assumptions are shaped by other aspects of culture and also contribute to the culture. Religions that prohibit the use of alcohol tend to have followers who (if they value their religion) drink less than followers of religions that don't address alcohol so directly. Many religious practices are also closely combined with other cultural practices, and the same religions may be practiced differently by different cultural groups.

Religion is an important component within a culture that contributes to definitions of what are acceptable and unacceptable behaviors, and helps shape how people understand life and its meanings. Many important social rituals derive from or involve religious concepts and ceremonies, including holidays, birth, death, and marriage celebrations. How sexuality is defined and practiced may be especially shaped by principles conveyed through formal religious teachings.

Impact of Religion On Treatment, Prevention, and Recovery.

Religious institutions can be important in designing and conducting prevention programs, and an important support for recovery. (We will consider spirituality as a component in recovery programs in Chapter 6.) Conflicts that have religious components may be combined with problems that have alcohol and other drug components, so religious elements may need to be a part of treatment in other ways as well.

Regional Differences

Within a country or larger cultural grouping there are likely to be cultural variations that are important to consider in understanding important differences among people. Language patterns, the pace of life, key values, gender expectations, food, dress, and many other cultural elements may vary greatly from region to region, and even among subgroups within a region. Such differences will be especially important to assess and incorporate into prevention planning, so that programs are consistent with cultural practices and address the particular risk factors within that location.

Consider, for instance, some of the lifestyle differences that you know about in different parts of the United States. Some of these are linked to weather and climate differences, some to the cultural backgrounds of the peoples who first settled each area, and others have evolved through the history and traditions of the region. These differences affect how alcohol and other drugs are used, what types of drinks are preferred, and local and regional laws and enforcement of those laws.

Whether an area is rural, suburban, or urban is also important. These environments affect lifestyles; what resources and recreational opportunities are available and preferred; what behaviors are frowned upon, prohibited, or tolerated; and what social groupings are available and valued. Different drugs are available in different locations, gender expectations may be more or less narrow, and the nature of social support options may be quite different.

A closely knit small town, for instance, can provide lots of support in times of crisis for its members. A town where everyone knows everyone else can be comfortable and strengthening, or can feel limiting and terrible, especially if a person feels that he or she cannot live comfortably within the expectations of the town. It would feel alienating and lonely, for instance, being a boy who does not like football in a small town where everyone goes to the high school football game every week and where every town official once played football! If people associated liking

football with masculinity, and believed that every boy who wasn't "masculine" must be gay, the social pressures to learn to like football would be even stronger. In a large city, with a great diversity of things to do, these types of pressures would be less, but the choices among peer groups and options might generate different types of stress.

Ethnicity and Ethnic Groups

Ethnicity is another way that groups differ from one another. Anthropologists define an **ethnic group** as a subculture within a larger culture, and often one that is "marginal" (seen as different and more outside the mainstream of the larger culture). Often the term "dominant culture" is used to indicate the main culture, and ethnic group to indicate a subculture different from the main culture in important ways. Since the United States has developed through the migration of people from many cultures, there is a long tradition of ethnic groups. The terms **assimilation** and **acculturation** are often applied to processes through which subgroups with different cultures gradually become familiar with and then more like the dominant cultural practices within a community or a country. How acculturated a person or group is, or wishes to be, will be an important factor in how best to approach them with prevention or treatment methods. Conflicts between cultural values and people ending up with no stable cultural foundations can occur when cultures interact and put people at risk in many ways.

Currently, many groups are working to redefine the overall culture as a multicultural one, and the term ethnic group has acquired somewhat different meanings in these processes. People are now being encouraged to explore, recover, and value their historical and cultural roots. Multicultural theorists have challenged the image of the "melting pot," noting that this notion most often forced people to shed their ethnic identities and adopt "American" cultural norms and values. With this shift in emphasis, ethnic groups today tend to be used more interchangeably with subculture.

Ethnic Group Issues and Concepts

As each group of refugees or immigrants has entered this country, they have sought to find places for themselves in the overall fabric of its communities. Early in our history they often settled together, and were frequently very poor until they found employment, learned to speak English, and became familiar with cultural traditions. Some groups worked to preserve their cultural heritages and preferred that their children marry others of the same cultural and religious background. Others were concerned that their children become "American" quickly. Each generation faced its own problems in adapting to the new culture.

The first generation often experiences major culture conflicts between the culture they came from and the United States. The children are likely to learn the language and customs first, and may act as translators and culture-brokers for their parents. The second generation of children is often concerned with breaking away from the older traditions, and there may be major conflicts between the children and their parents. Later generations may wish to recover some of the earlier traditions. Many resource materials are available for the clinician to understand these cultural and intergenerational patterns within families and how to work with them.

Some cultural groupings have stayed marginal within the society, either because they look different from the most-valued physical norm or because they have experienced discrimination within the larger society or because their cultural traditions have been less compatible with those

dominant in this country or because they have chosen not to assimilate. Histories of exploitation are important elements in whether groups have been encouraged, allowed, or have wished to become full participants in the society.

Native Americans were those present before Europeans arrived. Early European settlers and later government policies violated their cultural traditions, rights, and social organization. Many African-Americans were first brought here as slaves to work the plantations of the South and take the place of the servant classes that existed in many European countries. Those who have the Spanish language in common bring many heritages and histories to this country—from Mexico, Puerto Rico, and more recently Central and South American countries and Cuba. Beginning in the 1890s, Jews arrived in greater numbers. The initial Asian-Americans were a source of inexpensive labor; they arrive now from many Asian countries for a variety of reasons.

The experiences of these groups in this country have been shaped by the ways in which they first arrived, the educational and class backgrounds they brought with them, the nature of their cultural practices, and many other factors. Issues facing them today are affected by many factors as well. Some groups and individuals are still primarily identified with their subcultural groupings; they may speak little English and know little of dominant cultural traditions. Others may be bicultural, fluent in both their subcultural norms and practices and in the practices, language, and norms of the larger society. Some may experience significant degrees of culture conflict, clashes, and incompatibilities between their subgroup culture and the demands and traditions of the larger society. Still others may identify primarily with the larger society and its practices, and know little about, or reject the traditions of their subculture.

Cultural Implications for Treatment and Prevention

Each of these cultural circumstances has many implications for prevention and treatment. For those primarily identified with their subculture, the norms and practices of their subculture will predominate with regard to patterns of alcohol and other drug use and other elements. Treatment and prevention programming will need to be compatible with these subcultural traditions and practices, and will probably need to be carried out by those trusted within those cultural groups, often called *indigenous* healers (meaning using practices from within the culture).

Those who are comfortably bicultural probably can be reached in many ways, as long as the programs recognize their bicultural situations and the ways they may need to combine different aspects of their lives and identities. In fact, bicultural individuals can be very important in helping to design programs that will build on cultural traditions and practices because they have knowledge and skills in both cultures. They can also form a link between those in the alcohol and other drug use field with knowledge of prevention and treatment but not of a particular cultural group and the indigenous leadership within the cultural grouping.

Those experiencing culture conflict usually experience great stress and tension and have not found ways to integrate the conflicting demands and practices. They may be ambivalent about both cultures, may not fully understand either, and may not have good language or communication skills in either language. They may feel there is no place for them, and are often at high risk for many problems, including those with alcohol and other drugs. Resolutions of culture conflict can take many forms and sometimes can lead to more integrated bicultural orientations in which elements of each culture are combined, or may lead to stronger identification with one of the cultures. Usually the process involves developing more knowledge about each of the cultures, identifying the points of conflict, and developing ways to address

them.

People who experience culture conflict are often in pain, and eventually violate the norms and practices of both cultures, so they experience problems with members of both cultures. Elements of culture conflict are sometimes misidentified—possibly as a psychiatric condition, lack of motivation, or problems with authority and structure. In fact, these other elements may be present, as reactions to forces the person may not understand or be able to identify, in ways that she or he can address them. Clear identification of the issues can assist a person to feel less out of control and that there is some hope of resolution.

Each ethnic group has historical elements and cultural forms and practices that one needs to learn about if one is to understand that culture and to work effectively with people from that ethnic group. It is beyond the scope of this manual to discuss even the major ethnic groups, except to indicate some of the main ways in which they are likely to differ from the “dominant” assumptions within the United States.

American culture has traditionally stressed individualism and achievement as signs of success: autonomy (making it on one’s own), instrumental competence (skills in managing tasks), self-control (including “mastery” of feelings), and achievement of increased property (money, possessions) and power.

The dominant modes of problem solving have focused on identifying “causes” and then solutions to them, and have emphasized logic and use of symbolic language to explain behavior. Challenging, or at least questioning, those in positions of authority are seen as important strategies in helping the society to change and the person to grow and develop. These are *not* the primary values of many ethnic groups in this country or around the world. In addition, the dominant models of therapy and helping in this country tend to emphasize the importance of insight (self-understanding), and have involved self-disclosure (public examination, at least with a therapist or counselor, and often in a group situation) of one’s problems. These modes of “help” and growth are not compatible with many cultural styles without substantial preparation or modification.

In many cultures, restraint in the expression of feelings is important, and self-disclosure is considered not polite and offensive. Direct eye contact conveys lack of respect, not openness or attentiveness. Respect is conveyed through silence and acceptance of who one is, not by talking and questioning to determine what the other person means to convey. Meanings of life are often conveyed through “stories” from which the individual can derive their own meaning; intuition rather than logic may be valued. Spelling out exactly what the teller intended the meaning to be is considered insulting to the listener. Personal space may be defined differently, with either more or less space allowed between people who are communicating. A person seeking help may wish advice from an expert, and being asked to share feelings will violate cultural norms and increase shame. Spirituality and connectedness may be stressed, not rationality and separation. Being “on time” for appointments may not be important, especially if this competes with meeting family responsibilities. Families are less often defined as nuclear (mother, father, and children) but also include grandparents, aunts, uncles, cousins, and even others not directly related. Group-based cultures operate very differently than those in which the individual is stressed.

One’s learning about culture needs to include understanding the implications of relevant historical experiences and the origins of cultural practices. Knowledge and experiences with different elements of communication should be included: of interpersonal space, types of body movements

and what they convey, elements of language other than words (e.g., tone, inflection, volume, and directness), and whether the emotional context is high, low, or different in other ways. How authority figures are defined and respect is conveyed will be important, how families are defined and valued, communication styles, and so on. Even health and help-seeking may be defined very differently in different cultures.

Social Class

Within all of the above, there are **class** differences, in every subculture, among women and men, across all age groups. Class distinctions have been very clear and unchangeable in many societies, an example being the caste system in India. The level of society into which one was born determined what occupations one could pursue, one's lifestyle, and one's social worth. It was very difficult to move out of the class of one's birth. In the United States there have been more options for moving out of the class of one's birth, and many prefer to believe that it is not a stratified society. However, class differences remain and have strong effects. We use terminology like lower-, middle-, and upper-class, working class, leisure class, and most recently, underclass. Note that some of them are linked to level of status within the society (power, and access to and control of resources) while others infer something about lifestyle.

Class has been traditionally defined by several measures: educational achievement, occupation, income level, place of residence, and key social values held. In earlier periods of American history, those with more education were likely to be in particular occupations, and more likely to earn higher levels of income. Those with similar levels of income and types of occupations tended to cluster in particular neighborhoods and, in fact, people thought to be of a lower class were often kept out of particular neighborhoods, even if they could afford to live there. These relationships are not as strong today, so defining class is now somewhat more difficult. Class differences clearly remain, however, and influence opportunities and options, and are relevant to understanding alcohol and other drug use in several ways.

Influence of Social Class On Prevention and Treatment

Social class is related to the use of drugs in at least three different ways: drug availability, acceptability, and (if problems develop) accessibility of services. Drug availability is heavily affected by one's finances, since alcohol and other drugs must be purchased or acquired through other means. Those with higher incomes have more money to purchase alcohol and other drugs and are likely to buy more expensive brands. Thus, level of income may influence both how much one consumes and what type and brand one buys. Higher-income drinkers are known to buy more "hard" liquor than beer, and overall, they drink more alcohol. Cocaine used to be a very expensive drug, affordable only by those at the upper end of the economic ladder, and so it was viewed as a "high-class" drug. Crack, an inexpensive form of cocaine, is popular with lower-income users.

Availability is influenced by one's neighborhood and social network (family, friends, acquaintances). We are most often introduced to drugs and taught how to use them by people we know. If we live in a neighborhood in which drug trafficking is common and visible, the drugs currently "on the street" are likely to be those we first use. If the home (parental) liquor cabinet is one's primary exposure, then alcohol may be the drug one first adopts.

In addition to availability, social class is also a major indicator of lifestyle and a whole range of

behavioral and cultural preferences. These can include the types of work that are valued, choice of clothing, food, style of language, recreational activities that are meaningful and fun, living arrangements, and so forth. Many of these are determined initially by what one can afford, and are also shaped by cultural traditions and values. Also, when an individual has been socialized into a family at a particular level of income, they often come to be most comfortable with and prefer aspects of the lifestyle in which they were reared. Even if they try to get rid of any signs of that early lifestyle, remnants in accent or etiquette may remain, and will be detected by others who are conscious of class difference and wish to preserve the advantages of a higher-class status.

Service accessibility is also related to class, partially because of the availability of insurance in some types of jobs, and the ability to pay for treatment out-of-pocket if one's income is high enough. Also, some types of communities have access to more and different types of services than others, and many do not have the option of traveling to get to the services they need. Especially in poor neighborhoods, many of the available services may be closely tied to the criminal justice system, with few other options available.

Social Regulation and Deviance

Another important sociocultural perspective focuses again on how a society or community regulates the behavior of its members. We have discussed elements of this in our previous discussion of norms. This regulation is necessary to balance individual wishes and needs with others' needs and wishes, and to create ways to organize and manage needed goods and services. A society must develop procedures that will help it survive and support its members. To do this societies define what is acceptable and unacceptable, or "normal" and most societies also end up valuing some types of people more than others. One way that this happens is to define "normal" and acceptable by labeling some people or behaviors as "abnormal" or unacceptable.

Those whose behavior is **deviant** (unusual or different) from most people can be admired or perceived positively as wise or spiritual leaders (such as geniuses or prophets). They can also be perceived and labeled negatively as mentally ill, criminals, or addicts. When they are labeled positively, society is likely to develop ways to integrate and support them. When they are labeled negatively, they are more likely to be separated from the larger society, and to have difficulty being accepted as productive members of the society.

These social dynamics may mean that the only positive relationships and support readily available to those defined as deviant in some way are with others who are also labeled as negative deviants within the society. As individuals more and more associate with others who are also defined as deviant, their relationships with persons engaged in more "acceptable" behaviors and roles are decreased and become more strained. A vicious cycle can develop, with less and less connectedness to social factors and relationships outside.

One of the reasons why **deviance** is discussed at this point in the chapter, rather than nearer the section on peer groups and norms, is that being *defined* as deviant in one area makes it more likely that one will be defined as deviant in other areas. Class is one of the dimensions that is often related to people being defined as deviant within the larger society, since those with lower-class lifestyles and less access to resources are often seen as deficient in other ways, as are those who are looked down upon because they are ethnically different. Also, being defined as deviant usually leads to other patterns of discrimination.

Influence of Deviance On Prevention and Treatment

Once a person has been labeled as deviant in some way (for instance, identified as a troublemaker at school, or perceived as a “tomboy” long after girls should have lost interest in those activities), prevention approaches either need to work within the larger society to change the definitions of deviance, or the individual has to be assisted to translate skills and orientations learned in deviant roles to other types of activities.

Many examples of trying to change deviant labels exist in the alcohol and other drug use fields. For instance, one of the strategies behind the development of the concept that “alcoholism” was a disease was to help people stop defining alcohol problems as moral lapses and problems of willpower and sin, and to make it possible to get insurance for treatment of these problems.

One of the ways that people can be defined as deviant is through their use of particular drugs or by using alcohol and other drugs in particular ways. They can adopt the use patterns after they have begun to move into deviant roles, or they may gradually acquire more deviant roles once they have begun their use. Some sociologists have studied the progression of alcohol and other drug-using behaviors as examples of “deviant careers” in much the same way that they have studied the development of other careers. Gradually, one’s friends and activities become centered on using behaviors, and one can understand the decision to stop in similar ways to the decision to change careers.

An understanding of deviance and the mechanisms that create and sustain it is also important in the discussion that follows, since, once deviant patterns emerge, many aspects of discrimination occur. Also, if one is a member of a group that is discriminated against within the larger society, one is far more likely to be perceived as acting in deviant ways, whether or not one does, than if one were a member of a more socially accepted group.

Prejudice and Institutionalized Discrimination

The last dimension of concern also crosses all of the previous ones and often interacts with the previous ones. It is important because it helps to shape drug use patterns and consequences, and its effects are important to address in prevention and treatment programming. People are targets of discrimination because of their race, ethnicity, religion, gender, sexual orientation, social class, physical ability or disability, and age, and often because of a combination of factors.

Discrimination can mean negative attitudes and stereotypes which influence people’s judgments about others, and make it much more difficult to have one’s work evaluated fairly. This is often called **prejudice**. It can limit access to jobs, important social groups, and other opportunities.

Even when it is illegal to discriminate overtly, negative attitudes and assumptions can affect people’s judgments in many subtle and hard-to-detect ways. History shows us that patterns of discrimination can be perpetuated in policies and practices that are difficult to uncover and even to recognize, especially if they have become embedded in common practices; these system-level patterns are often called “institutionalized discrimination.”

Different forms of discrimination have been given different labels. For example, racism is discrimination based on racial physical characteristics, often connected to assumptions about the abilities that people with those characteristics have. You might have noted that race has not been previously discussed in this chapter. The major reason for this is that most racial categories have no biological meanings in which biological differences are relevant to the types of stereotypes

people have about different groups. Problems with the concept of race include: (1) the biological characteristics that are used to define races are present in many other groups of people, either separately or in combination; (2) the abilities and characteristics associated with different racial groupings are not linked to those biological characteristics; and (3) many of the lifestyles and other issues often linked to race are really *economic*, *cultural*, or *ethnic* factors, and have been included there.

Race certainly has many political meanings, and also, the groups who experience discrimination based on race concepts have claimed many aspects of race as a way to build ethnic pride and group solidarity, such as to be proud of being black and to change narrow standards of beauty. Thus, in these ways, it has meaning, but not as a biological concept. We usually use racism to apply to discrimination against the major protected groups within the United States: Native American, African-American, Asian-American, and Latina/o.

Discrimination in this society often leads to reduced income, limited opportunities for jobs, a need to hide who one is from colleagues in order to be perceived as competent, and a constant monitoring of one's own behaviors to be sure that they are not breaking any social norms about appropriate behavior.

Other forms of discrimination are given other labels; for example, sexism is the term used to designate discrimination on the basis of gender, and anti-Semitism refers to discrimination against Jews. Those whose characteristics are accepted and comfortable for those in positions of power do not need to maintain this social vigilance in the same ways, and often are helped toward advancement (and even safety and protection) by those in a position to help them. Even more ominously, discrimination is linked to violence in this society—sometimes actual physical violence such as rape, ethnic incidents, homophobic attacks—and much interpersonal and psychological violence (erosion of self-esteem, hatred of what one looks like, shame about one's family) that may do even more damage than the more obvious physical forms.

We must also mention the impact of a physical disability on the use of alcohol and other drugs. People can be born with some physical limitations (for example, in the areas of seeing, hearing, or movement) or they may acquire limitations later in life. Alcohol and other drugs can be a factor in accidents that lead to disabilities, or use can occur as part of an individual's efforts to cope with their difficulties. Disabilities create many challenges for the people who have them and for those who design effective prevention and treatment approaches.

The topic of discrimination is a large one, and we can not do justice to it in what remains of this chapter. All of the types of discrimination have distinctive elements, and there is information specific to each that one should learn over time. They also have many dynamics and consequences that are common.

Implications for Future Counselors

Two important concepts are very important for those wishing to become counselors: “internalized discrimination” is one set of ideas, and “constructive suspicion and resistance” is the other. Internalized discrimination refers to ways that people internalize how others react to them and all of the subtle ways in which social status is conveyed. Most people can identify more blatant examples of discrimination—hate-focused comments, actual violence, or openly discriminatory statements. The more subtle manifestations are more difficult to recognize and protect oneself against—cues in body language, indicators of fear or discomfort, not being sure why one did not

get a job, and so on. These cues and the many discouragements that accumulate when one's work and progress are not helped are often misinterpreted as personal failures, social discomfort, and so on. They can eat away one's self-esteem and confidence. Once their sources are identified, the person is more able to resist their negative effects because they can view them as problems of society and not one's own failures. Many of them are very subtle, however, and hard to identify.

Dealing with internalized discrimination usually takes at least some sharing with others who have experienced similar incidents in order to identify their commonalities and clearly label their source. Of course, one must also always examine how one's own behavior interacts and contributes to negative situations, and this may be even more important when one's behavior is likely to be misperceived and interpreted. When discrimination is also at work, however, feeling responsible and guilty for things that were done to you helps neither accurate problem assessment or problem-solving, and it is very damaging to one's self-esteem.

Learning more about one's history and learning to value the accomplishments of people in one's group are also important ways to diminish internalized oppression. Many people who grow up in a culture that devalues important aspects of who they are also learn some of those attitudes. Thus, they begin to believe some of the stereotypes and assumptions, and begin to hate themselves and others like them. Self-hatred that arises from one's social characteristics also leaves one with less confidence, less sense of worth and value, and some belief that one deserves the bad things that happen to them.

Alcohol and other drug treatment is difficult under the best of circumstances, but internalized discrimination, plus having to contend with more difficult life circumstances is likely both to contribute to the development of problems and create issues that must be addressed in treatment. Culturally sensitive services will help, but active work on uncovering the ways that discrimination has been internalized is also very important. Staff members who have experienced this phenomenon and with whom clients can identify and role model are important components in these processes.

Distrust and "constructive suspicion" are important to respect, since they are useful survival mechanisms when one lives in a world likely to be discriminatory. Counselors should expect to have to earn the respect of their clients, to have their ethnic assumptions and knowledge challenged and tested, sometimes quite subtly. This does not suggest that one's authority and skills are not respected, but rather that the person is trying to discover whether they and their culture will be respected. Safety is important in any treatment or change, and feeling safe is much more difficult when one has experienced discrimination. Being able to communicate clearly (with bilingual staff and people sensitive to language variations), having culturally compatible furnishings and styles of treatment, and having some time together for people with shared histories can all help to make this constructive suspicion less necessary. Without this, we make the tasks of recovery much more difficult, and increase the forces that lead to problems.

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